Dual Eligible Project Core Questions

Questions	Answers
Capitated Integrated Providers (CIP)	
1. How many CIPs per region?	
2. With multiple CIPs in a region, will there be enough volume for the capitated payment system to work for all of them? Any of them?	
3. The CIP approach may cause individual providers operating on thin margins to set up their own system by hiring internally to save on costs. This would create duplication of services across providers, with increased costs to the system. How would savings then come from "integrated" care?	
4. What responsibilities and authority does a CIP have? How will it work?	Responsibilities: Multidisciplinary teams to address full range of client's needs using a person-centered creative approach.
5. What degree of financial risk will be borne by the CIPs?	
6. How does the money flow to the CIPs?	
7. Who is eligible to become a CIP?	
8. What is the process by which a provider becomes a CIP?	
9. How will existing providers expand and integrate services?	
10. Providers will continue to serve non-dual eligible clients (64% of DS and 67% of CRT participants are dually eligible). How might providers administer two different systems?	
11. How will the CIP and CHT integrate with existing care coordinators from CFC, CRT, DS, TBI, etc?	
12. What are the parameters defining when a CIP provides services and when the BP CHT provides services?	

CIP = Capitated Integrated Provider; BP = Blueprint
CHT = Community Health Team

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Access	
13. Are all dually eligible individuals eligible to receive CIP services?	Yes
14. What is the threshold of need for having access to a CIP?	.
15. Are there individuals who cannot access a CIP?	
16. How does an individual access a CIP?	
17. How does an individual get "flagged" if there is a change in condition that would warrant offering the individual access to a care coordinator?	
18. Where is the entry point for a person whose primary services are not connected to a CIP?	
19. Can there be a population-based seamless way for a person to be referred for care coordination services who does not need a CIP?	Blueprint Community Health Teams?
Services	
20. Are services mandatory?	No, they are not.
21. How will services be provided for dually eligible people who opt out?	
22. Which services should be tied to infrastructure and which to the individual plan (e.g. should care coordination be considered a 'core capacity' and be separate from the Individual Budget)?	
23. Will Individual Budgets be used? If so, how?	
24. Can individuals self-manage without a CIP?	Under the design discussed to date, all CIPs need to support self-management. A person could utilize either a CIP, an ARIS arrangement (similar to current CFC), or a peer-organization.
25. How can we ensure a consistent and reliable supply of PCAs as part of the infrastructure?	
26. How will the system, including physician and care coordinator, know in real time that participants are admitted to the hospital and ER?	Possible methods include claims data or billing data; Community Health Teams; electronic health records, and/or a hospital obligation to report patient admissions and ER visits.

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Enrollment	
27. How will people enroll in a CIP?	
28. How will people disenroll in a CIP?	
29. How will the program handle dually eligible people who go on and off Medicaid?	
30. How would a person discontinue use of a CIP once needs have been met?	
Savings	
31. How will savings be measured?	
32. How will savings be shared with the person, the CIP, other providers, the State, CMS?	
33. If a CIP is available to all, how will we support the costs of additional care coordination? How will this affect savings?	
Already Decided	
1. Automatic Enrollment w/ easy opt out	
2. Capitated Financial Alignment model	
3. MCE as health plan	
4. MCE Grievance and Appeals process	
5. MCE Quality Assurance and Program Integrity	
6. MCE Single Formulary for Pharmacy	

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